level 3, 35-bed unit where the most critically ill neonates receive care. After a sustained 3-year period of zero CLABSIs, we identified 10 infections between September 2016 through April 2018. **Methods:** A multidisciplinary team known as the neonatal infection prevention team (NIPT) was reinstated. This team included members from nursing and infection prevention (IP) and from NICU Shared Governance, as well as a neonatal nurse practitioner (NNP) and a neonatologist to review these CLABSIs. Evidence-based practices, policies, and procedures were implemented to help reduce CLABSIs. Nurse educators provided education and training. The infection prevention team reinstated and modified the central-line maintenance and insertion tools to document compliance and to identify any gaps in care. Nurses were expected to document line maintenance once per shift (A.M. and P.M.). All CLABSIs were entered into the CDC NHSN and the hospital's safety event reporting system, which required follow-up by a clinical manager. The infection prevention team monitored NHSN standardized infection ratios (SIRs) monthly. The SIR is the number of observed events divided by the number predicted (calculated based on national aggregate data). **Results:** The highest reported quarterly SIR was 1.423, which occurred in the third quarter of 2018 (Fig. 1). Overall compliance with line maintenance protocols was 86% on the morning shift and 89% on the afternoon shift. With implementation of an evidence-based bundle, the NICU had a rolling 12-month SIR of 0.00 as of October 2019. **Conclusions:** Multidisciplinary team development, implementation of evidence-based bundle elements, and education on catheter care contributed to the long-term success in decreasing CLABSI rates in our NICU. Although this implementation achieved a zero CLABSI rate, we experienced some barriers, including compliance issues with staff not completing the audit tools, staff turnover, and high patient census.

Presentation Type:
Poster Presentation
Quality of Hospital Infection Control Programs in Low- and Middle-income Countries: A National Survey André Alvim, Centro Universitário UNA; Andrea Gazzinelli, Universidade Federal de Minas Gerais – UFMG; Braulio Couto, Centro Universitário de Belo Horizonte - UniBH

Background: One of the strategies to reduce healthcare-associated infections (HAIs) and promote the quality of disease prevention and control actions is the creation of a hospital infection control program. This program is a set of deliberately and systematically developed actions aimed toward reducing the incidence and severity of infections to the maximum extent possible. In Brazil, studies on the subject still need to be improved; they focus on structural and process assessments, especially the survey of continuing education indicators as a quality requirement for the prevention of HAIs. The organizational context does not contribute to the success of the program, and difficulties remain in implementing recommendations and in implementing patient safety policies. **Objective:** To analyze hospital infection control programs in relation to quality components. **Methods:** This cross-sectional epidemiological study was conducted in health services located in the 5 official regions of Brazil: Midwest, Northeast, North,
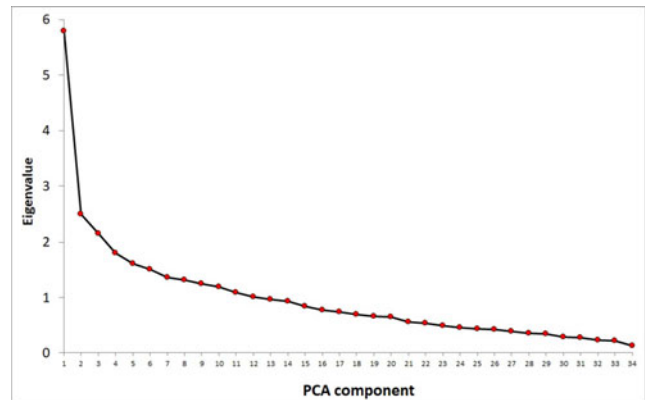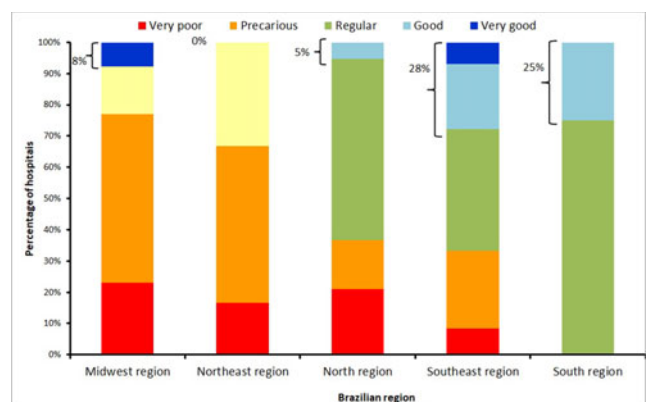

Fig. 1.

Fig. 2.

Southeast, and South. To select the study sites, nonprobabilistic sampling using the snowball technique was used. The potential study population consisted of 114 hospital infection control services. Health professionals responded to the structured instrument sent electronically via e-mail, and other health services near their locality, until reaching a national proportion. We used the "Hospital Infection Control Program Evaluation Questionnaire"; it consists of 36 multiple-choice questions. This tool was validated by 96 expert judges using the Cronbach's alpha test (0.82) and the content validity index (0.88). A data analysis was performed using the multivariate principal component analysis technique (PCA). **Results:** Overall, 13 PCA components (Fig. 1) were used to build a score for measuring the performance of the hospital infection control program (ie, IQPC score). The Southern region had the best performance of the hospital infection control program (mi = 1.50; $P = .02$) (Fig. 2), private administration (mi = 0.45; $P = .05$), of hospitals that contained 300 beds or (mi = 1.38; $P < .01$), hospitals that used the NHSN criterion for HAI surveillance (mi = 2.12; $P < .01$), and those who searched prospective activity as a surveillance method (mi = 0.51; $P < .01$). **Conclusions:** The quality of nosocomial infection control programs still needs to be improved among health services, highlighting the need to invest in small, publicly managed hospitals that use retrospective active surveillance methods.